PROVISIONAL POLICIES
FOR
PSRO DATA ROUTING AND PROCESSING

REVISED

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TABLE OF CONTENTS

SECTION		PAGE
I	Introduction	1
II	Provisional Policies for PSRO Data Routing and Processing	7
III	General Requirements and Constraints	10
IV	Approval Process for Implementation of PSRO Data Program	15
Appendix 1	PSRO Hospital Discharge Data Set (PHDDS)	
Appendix 2	Specifications for Confidentiality Policy on PSRO Data and Information	
Appendix 3	Discussion of Options	

I. Introduction

1.1 Current Data Activity Considerations

Program policy has until now precluded the development of PSRO data systems pending the analysis of all PSRO functions requiring automated processing support, the identification of total data requirements and the feasibility of developing a PSRO information system.

1.1.1 OPSR Task Force

In the fall of 1974, a task force under the sponsorship of OPSR, began investigating existing data systems and approaches. The first task force effort, completed in December 1974, produced an interim data systems model.

The comments from the Health Data Policy Committee and other reviewers of the task force report suggested that until PSRO data requirements were specified and available data systems were examined, systems design at the Federal level specifically for the PSRO program should not be undertaken.

A second task force, which began early this year, is now completing work on the identification of total information requirements.

1.1.2 Uniform Hospital Discharge Data Set (UHDDS)

The growing need of payors, governmental agencies, accrediting organizations, planning bodies, and others for patient care information from hospitals led to the development of the uniform hospital discharge data set (UHDDS) in 1971. The UHDDS was designed to be a minimum set of data, uniformly defined, capable of providing to all users basic and comparable information on all hospital discharges. The UHDDS was thoroughly and successfully field tested in a demonstration project funded by DHEW.

The UHDDS demonstration showed that the basic data items could be collected routinely, with uniform definitions, at various sites by different data systems.

In 1972, the Uniform Hospital Abstract Form Subcommittee of the U. S. National Committee on Vital and Health Statistics recommended the minimum basic data set. Minor modifications of this data set were made in 1974 for use in DHEW programs. The modified UHDDS with definitions is presented in Appendix I - Part A of the PSRO Hospital Discharge Data Set (PHDDS).

Identifying and defining a uniform data set was an important first step in meeting the need for multiple use basic data. A further need is for an abstract format for recording the data set. A unifor abstract format will limit costly and time-consuming data recording

in hospitals caused by a multiplicity of forms requiring duplicate recording of data. The Social Security Administration has developed an abstract form, the Uniform Hospital Discharge Abstract (UHDA), for the collection of the UHDDS. This form was developed in conjunction with the American Hospital Association. Implementation of the UHDA for the Medicare Program is expected to be completed by January 1, 1976.

Efforts should also be directed to the elimination of redundant data reduction, e.g., the preparation of the data into machine readable format. This process is costly in terms of time and personnel resources. Users of the data should avoid this step whenever possible in arranging for the acquisition of the basic data contained in the UHDDS.

1.1.3 PSRO Hospital Discharge Data Set (PHDDS)

To meet the PSRO need for data on all Federal hospital discharges, the PSRO Hospital Discharge Data Set (PHDDS) has been defined (Appendix I). Included in the data set are all the data items of the Uniform Hospital Discharge Data Set (UHDDS), Part A of the PHDDS, supplemented by a recently developed, limited number of PSRO-specific data which has evolved from PSRO policy development, Part B of the PHDDS. The PHDDS will be required on all Title V, XVIII and XIX patients reviewed by PSROs.

1.2 Current PSRO Data Needs

1.2.1 The nature of PSRO activities requires a continuous flow of certain types of information to and from each PSRO and associated delegated hospitals to facilitate review. Data are required to:

1. Develop profiles of patients, practitioners and providers.
2. Monitor and manage the concurrent review process.
3. Support Medical Care Evaluation Studies (MCEs).
4. Complete Federal reporting requirements as specified in the PSRO Management Information System (PMIS) Federal Reports Manual.

1.2.2 Some of this required data can be manually manipulated. The data to be automated is required on a routine, recurring basis and is of sufficient volume to make automation practical. The automated data can be classified into three categories: 1) the Uniform Hospital Discharge Data Set (UHDDS); 2) routine, additional data elements specific to the PSRO program which together with the UHDDS comprise the PHDDS; 3) optional data for local purposes to be specified by the PSRO. The following table shows PSRO activities

requiring automated data processing to meet all or part of the data need. Data necessary for profiling will be completely automated. The other activities require both automated and manually processed data.

EXHIBIT A

PSRO Activities and Data Processing Requirements

Activities	Function Characteristics	Processing Manual	Processing ADP
Profile Analysis	routine		x
Management and Monitoring of Concurrent Review Process	routine	x	x (selected data on each discharge)
Medical Care Evaluation Studies	non-routine	x	x (area-wide and higher volume)
Federal Reporting	routine	x	x (National data base--selected discharge data)
	non-routine		

1.3 Summary of Provisional Policy Approach

1.3.1 Factors Affecting Provisional Policy Development

The approach underlying the policy which follows is designed to enable newly conditionally designated PSROs to proceed to implement their data program within the immediate short range. It takes into consideration the following factors:

a. Minimal PSRO program data needs (described in 1.2.2)

b. Current Departmental policy and long range plans

c. Consideration for institutional recording and reporting burdens

d. Avoidance of redundant systems design and data input processing

e. Current information systems collecting discharge data

f. Multiple users of discharge data

g. Local autonomy and flexibility for PSROs

h. Need for improved quality and reliability of discharge data

i. Timeliness of implementation and processing turn-around by servicing organizations

1.3.2 Data Collection

In relating these considerations to the three categories of PSRO data outlined earlier, it became apparent that existing and proposed data collection systems could, with modification, meet PSRO needs. Emphasis is placed on a single data collection and data reduction for data common to many users (UHDDS). The UHDA being implemented for Title XVIII, is a prime example of the development of a uniform format for this purpose. It is recognized that not all duplicate collection can be eliminated until such time as use of a standard format becomes universal. The long range goal is to have all users of the UHDDS, including PSROs, claim payment agencies, State Cooperative Health Statistics Systems, discharge abstract services and planning agencies, receive these data through the use of a standard form and standard tape format. This approach substantially reduces the data collection efforts within hospitals and provides all users with consistent, compatible data to be combined with data from other sources to meet total data needs.

For PSRO purposes, hospitals will be required to collect the UHDDS elements consistent with the format of the UHDA. In hospitals not using a discharge data abstract system the remaining data of the PHDDS and optional data selected by each PSRO will be collected on a form to be developed locally by the PSRO in conjunction with the hospitals in the area. Hospitals using discharge data services will attach a copy of the form containing the UHDDS to the data service collection form. When a copy of the UHDA becomes available through Medicare and/or Medicaid, the Bureau of Quality Assurance will prescribe this form for use by the PSROs. The remaining data selected by the PSRO may be incorporated in the data collection form of the hospital data service.

Part B of the PHDDS is standardized and is to be collected on all Title V, XVIII and XIX patients. The third category of data, optional data elements to be determined by local PSROs, is variable and periodic. These data are to be selected locally to respond to specific needs within a PSRO area. The fact that PSROs require flexibility to collect locally determined data necessitates forms design at the local level.

Exhibit B illustrates the relationship of the three categories of PSRO data to the UHDDS and the local and Federal PSRO data requirements.

EXHIBIT B

Category 1	Core UHDDS - Part A of PHDDS	Standardized and permanent - needed by all users
Category 2	PSRO - Specific Data Elements - Part B of PHDDS	Standardized - needed by PSRO in addition to above
Category 3	Optional Data Elements	Optional elements added by each PSRO

The provisional policy recognizes the need for providing reliable and valid data. To assure this quality PSROs will monitor data collection activities in each hospital. Trained personnel in the hospital who use the medical data regularly and are familiar with the data can be expected to meet the PSRO need for quality data upon which to make review decisions.

1.3.3 Uses of Data

The PHDDS has been developed to meet minimal PSRO needs for data. Combinations of the data elements in this set can be used for:

1. Profiles,
2. Management Reports,
3. Self-Evaluation Purposes,
4. Development of Local Norms.

At the Federal level, a subset of the PHDDS from each PSRO with individual identifiers removed will provide a data base for the development of Federal reports. Magnetic tape specifications for the subset will be provided by DHEW. Optional data elements will be used by PSROs primarily to support area-wide MCE studies with limited flexibility to PSRO effectiveness.

The uses of PSRO data are illustrated in Exhibit C.

EXHIBIT C

Data	Use: Local	Use: Federal
PHDDS (routine)	Profiles Management Reports Self-evaluation Norms	Federal Reporting Data Base (subset)
Optional Data Elements (variable)	MCE Studies Local Flexibility	------ ------

1.3.4 Processing of PSRO Data

The approach to meeting PSRO data needs by building on the common data needs of multiple users provides the opportunity for existing systems to process PSRO data. Data processors must be prepared to integrate all PSRO data to produce required reports in a time frame appropriate to PSRO requirements. PSRO data processors will be selected competitively. It is assumed that existing systems will elect to compete and will be in a position to provide data processing services more satisfactorily due to prior experience with PSRO-type data. And at less cost due to the data needed by PSROs is already incorporated in the system. Among the data processors considered in the proposed policy are the Cooperative Health Statistics System, the data systems serving the Medicare Program, the Medicaid data systems, existing concurrent review systems and the existing discharge abstract services.

1.4 Summary Of Provisional Policy

The major thrust of the proposed policy is to avoid redundancy of data collection and reduction and to provide high quality data to PSROs while, at the same time, recognizing the needs of other data users and the experience and capability of existing data systems. The policy addresses the following areas:

1. Data to be collected (Inputs)
2. Data Deliverables (Outputs)
3. Confidentiality and Privacy
4. Operational Constraints
5. Funding
6. Data Collection Options
7. Subcontracting
8. Systems design and development

It is intended to permit PSROs to implement effective review programs supported by reliable, responsive data services.

II. Provisional PSRO Data Policies

Newly designated conditional PSROs will be expected to comply with all of the following provisional policies governing automated data processing from July 1, 1975 to June 30, 1976. Experience gained from the implementation of the provisional policy will be reflected in the development of final policy. These provisional policies are further defined under General Requirements and Constraints, Section III.

2.1 Data to be Collected (Inputs)

The conditional PSRO shall at a minimum collect or obtain all data contained in the PSRO Hospital Discharge Data Set (PHDDS),* Appendix 1. This data set will be obtained for all Federal program beneficiaries discharged from acute care hospitals for which charges are paid in whole or in part by Titles V, XVIII and XIX of the Social Security Act.

2.2 Data Deliverables (Outputs)

The conditional PSRO shall at a minimum obtain from the data processing contractor patient, practitioner and institutional profiles and management reports of concurrent review activities on a regular basis with the format and frequency of these reports to be mutually agreed to by the PSRO and the PSRO-delegated hospitals. In addition, the PSRO will arrange to deliver each calendar quarter to the Bureau of Quality Assurance (BQA) Central Office a data base tape containing a subset of the PHDDS data elements prescribed by the Bureau. (See Appendix 1 - the PHDDS). Conditional PSROs designated prior to March 1975 with approved data systems will continue to use their existing local reporting system but will be required to develop a plan to meet Federal reporting requirements as outlined in the Federal Reports Manual of the PSRO Management Information System (PMIS) including the submission of data base tape. These PSROs will also be required to develop a plan to come into compliance with the provisional data routing and processing policy at least 60 days prior to the renewal of contracts with DHEW.

2.3 Confidentiality and Privacy

Data supplied to the PSRO by a processing organization will contain coded identifiers of patients, health care practitioners (physicians and other health care professionals) and health care facilities; data base tapes containing the prescribed subset of PHDDS elements prepared by the processing organization for the PSRO for use at the national level by BQA will be expunged of all elements identifying patients and health care practitioners, but shall include coded identifiers of health care facilities. The PSRO and processing organizations will be required to comply with the other provisions contained in the appended confidentiality specifications (Appendix 2).

*The Uniform Hospital Discharge Data Set plus additional PSRO specific data elements.

2.4 Operational Constraints

Conditional PSROs shall not purchase, lease or maintain data processing equipment or facilities.

Conditional PSROs designated before March 1975 with established data processing capability approved by the Department of Health, Education and Welfare will continue present modes of operation until they are required to come into conformance with provisional policies (see 2.2). Meanwhile, they may not expand their data processing capability or data coverage to other segments of health care delivery without prior approval of the Department.

2.5 Funding

PSROs will be funded a maximum of 75 cents per Title V, XVIII and XIX discharge reviewed which will cover all costs of automated data processing from receipt of forms or other input to delivery of specified data, including any other routine or non-routine processing that may be negotiated on an individual or group basis with the data processor.

2.6 Data Collection Options

The conditional PSRO will use one of the two basic options for collection of its data:

2.6.1 In recognition of the problems and cost associated with duplicative recording in the collection of data, the PSRO will first be required to look to those Federal and State government supported and funded data systems or non-governmental hospital discharge abstract service organizations which currently collect discharge data on patients from hospitals in the PSRO area. This will include those government supported systems which are prepared to collect discharge data in the near future. If these data organizations agree to meet data collection and routing requirements contained in paragraphs 3.1 and 3.2, the PSRO and the PSRO delegated hospitals will use such services for collection of needed data.

2.6.2 If these discharge data systems do not agree or cannot meet all the requirements defined in paragraphs 3.1 and 3.2, the PSRO will make such other arrangements with these or other sources as necessary for data recording and collection in conjunction with the hospitals in its area subject to the requirements and constraints contained in Section III. (Refer to Discussion of Options, Appendix 3)

2.7 Subcontracting for Processing Services

The PSRO will subcontract for data collection, routing and processing services subject to the requirements defined in paragraph 3.3. All subcontracts will be competitive for the processing of data deliverables

outlined under 2.2 and for other services that may be desired by the PSRO within the cost constraint of 2.5. Thus, a PSRO may enter into a single subcontract, where (a) an existing data collection and processing organization (2.6.1) can provide satisfactory profiles and other tabulations and services on a competitive basis, or (b) in the event a new data recording and collection system is established (2.6.2) and copies of the PSRO forms are submitted to the single processing organization. Two or more subcontracts will be required where the data collection organization in 2.6.1 only furnishes magnetic tape records of PSRO peculiar data to the selected data processing organization. One or more with the data collection organizations to cover the costs of machine entering the additional PSRO data elements and furnishing the tape; and one with the data processing organization for producing profiles, tabulations and other specified data.

2.8 Design and Development

For the provisional period, the Department will discourage PSRO funded new and duplicative design and development efforts or the inclusion of design and development costs as a separate item in proposals and bids. It will encourage the use of software packages designed and developed to meet minimum PSRO needs where the design and development costs have been prorated as an investment to obtain PSRO processing service and business. Software packages designed and developed to meet PSRO needs must be made available at a reasonable, negotiable price to the Federal government which shall have full rights to publish or use such materials without restrictions.

III. General Requirements and Constraints

The PSRO will be guided by the following policy requirements and constraints in arranging and negotiating for data collection and automatic processing services.

3.1 For Data Collection:

(Applicable to existing and proposed data collection processes).

3.1.1 The system at a minimum must include the PHDDS and optional data elements needed by the PSRO.

3.1.2 Those hospitals to be delegated PSRO review functions must agree in writing to collect and provide to the PSRO minimum PHDDS and optional data.

3.1.3 The system should be capable of inputing PSRO data within 90 days from the start of review by the PSRO and delegated hospitals, subject to DHEW approval of subcontract(s).

3.1.4 The PSRO, data processing organization and delegated hospitals must agree to the establishment of in-house procedures for controlling the quality of data collected. Suggested procedures for data collection will be furnished by BQA.

3.1.5 The PSRO will require the use of the ICDA-8 for coding diagnosis and surgical procedures to the fullest possible extent. Any data collection of diagnoses and procedures initiated by the PSRO is to be coded in ICDA-8. The H-ICDA-2 may continue to be used during the provisional period for generating profiles and other reports for local PSROs where the majority of hospitals in the PSRO area use the H-ICDA-2 coding system and the abstract service organization has been competitively selected by PSRO to provide processing services. All data base tapes furnished to BQA will be coded in ICDA-8 or H-ICDA-2. When ICDA-9 becomes available, all diagnoses and procedures will be coded accordingly. PSROs will be given a reasonable time period to allow for conversion to ICDA-9.

3.1.6 The data elements contained in the Uniform Hospital Discharge Data Set are to be collected on all Federal patients in the UHDA format. Until the UHDA format is available, PSROs will make local arrangements for the collection of the UHDDS on an interim basis subject to approval by BQA.

3.1.7 In the case of current discharge abstract systems, it is acceptable to add data fields to existing forms to accomodate the standard PSRO

specific data (Part B of PHDDS, Appendix 1), any data elements recommended by BQA to link the UHDDS form with the existing form, if necessary, and the local optional data.

3.1.8 In cases where a form will have to be designed for the collection of the standard PSRO specific data, the data elements to link the UHDDS form with the PSRO data collection form and the local optional data, the PSRO will work with the hospitals in its area on the form layout, number of copies, etc.

3.1.9 The data collection organization will abide by the specifications for confidentiality outlined in Appendix 2.

3.2 For Routing:

(Applicable to existing discharge data collection processes, and to Medicare and Medicaid where discharge abstracts will be used as an integral part of the claim).

3.2.1 In the event the existing discharge data collection organization does not provide data deliverables and other services for the PSRO, it must agree to deliver data base tapes to the PSRO or its processing agent containing the PSRO required data on a reasonable schedule to be determined by the PSRO.

3.2.2 The record format of the magnetic tape to be delivered from the existing discharge data collection organization to the PSRO processor will be, where mutual agreement cannot be reached between the collector and the processor, established by the source data collection organization serving the greatest number of hospitals. These tape specifications will be documented and must be made available through the PSRO or the Department to interested vendor organizations.

3.2.3 Where Medicare and/or Medicaid can provide a copy of the UHDA this copy is to be attached to the form(s) containing the PSRO required data as described in parpagraph 3.1.7 and 3.1.8.

3.2.4 The existing discharge data collection organization shall have programs and procedures to edit for consistency, reasonableness, and completion of data sufficient to assure no more than a one percent error rate in the data base entered on machine readable files from completed abstracts submitted based on the formula: (number of data element errors/total data elements) X 100.

3.2.5 Costs associated with correcting errors in data recorded at the hospital shall not be included in the seventy-five cent rate per discharge reviewed.

3.2.6 The data collection organization will charge the PSRO only those costs associated with machine entering the additional data elements to be collected solely for PSRO purposes and for preparing and furnishing the data base tape(s) to the PSRO or its processing agent.

3.3 For Automated Processing Services:

3.3.1 Any data processing organization providing automated processing services to the PSRO which receives actual copies of abstracts directly will comply with the edit provisions of 3.2.4.

3.3.2 The PSRO and the data processing organization will comply with the specifications for confidentiality (Appendix 2).

3.3.3 The data processing organization must be able to generate a set of profiles and management reports to the PSRO and associated delegated hospitals formatted according to contract agreement, as well as a data base tape containing the subset of the PHDDS elements prepared according to Department specifications.

3.3.4 The data processing organization must agree that the reports will be delivered to the PSRO in a reasonable time frame to be specified by the PSRO; and that the national data base tape containing the subset of the PHDDS on Federal discharges for that period will be delivered within 60 days following the close of a quarter.

3.3.5 Any data processing organization wishing to provide automated processing services to the PSRO must be operationally ready to provide such services within a period of time to be specified by the PSRO to coincide with its review and management activities. In this regard, the PSRO will be obliged to take action at the earliest time to provide the interested systems organization with as much lead time as possible.

3.3.6 The PSRO will be funded a maximum of seventy-five (75) cents per Federal discharge reviewed which will cover:

3.3.6.1 For data processing organization currently collecting or preparing to install a Federal discharge data system (Federal or non-Federal supported):

a. Incremental costs of forms, handling, editing, and keying additional PSRO specific data elements into machine reproducible language.

b. Full costs of preparing and furnishing a magnetic tape to the PSRO or its processing agent where applicable (routing).

The formula for computing the incremental costs:

$\frac{Pc}{Tc} \times 100$ = percentage of total cost chargeable Federal patient abstract

where,

Pc = total number of characters comprising the additional PSRO specific elements per abstract (the additional PSRO data elements do not include UHDDS elements already being collected).

3.3.6.2 For the PSRO selected data processing organizations where they receive copies of the abstract forms from hospitals in the PSRO area - all costs of handling and processing the Federal patient abstracts from receipt to machine entering on computer files.

3.3.6.3 For data processing organizations which will maintain and generate PSRO deliverables, whether they are the original collection organization or competitively selected to provide only the services under this subparagraph - all costs associated with providing the deliverables and any additional processing services, e.g., Medical Care Evaluation Studies (MCEs).

The total amount to be funded will be governed by the PSRO phase-in plan and will be based on the estimated total number of Federal discharges reviewed by PSRO delegated and non-delegated hospitals during the contract year.

3.3.7 Subcontracts will be competitive except if an existing data system currently collecting discharge data from all federal patients from hospitals in the PSRO area can meet the requirements above for both data

collection and processing and its processing services are competitively priced such that the total per discharge price is clearly less than a competitive alternative. In the latter case, the Department reserves the right to waive the competition requirement.

3.3.8 PSROs shall issue a Request for Proposal (RFP) which will at a minimum (a) allow for submittal of existing and developed software packages that have been developed to support PSRO needs and (b) require potential contractor to submit total costs for services on a per abstract basis.

3.3.9 The PSRO, while it will have flexibility to negotiate for services within the cost constraint imposed, shall not be allowed to reject submitted vendor-proposed report packages without sufficient reason. The PSRO will be expected to make the most suitable choice from among those available. Similarly, in cases where it is mutually advantageous for a group of PSROs to negotiate as a group for services, a PSRO must be able to substantiate its reasons for non-participation.

3.3.10 During this provisional period the Department, may, in selected instances, provide funding in excess of the seventy-five (75) cents for the collection and processing of data elements as part of a study program to determine the effectiveness of data elements and their combinations for longer term used by all PSRO(s). In such cases the PSRO will need to justify the additional routine elements and provide separate cost estimates for those elements besides the PHDDS which will be collected and processed for seventy-five (75) cents, and the additional elements and their per discharge cost in excess of seventy-five (75) cents.

3.3.11 The National Data Base tape(s) containing the subset of the PHDDS will be delivered to the Department without coded identifiers of patients or health care practitioners but including coded identifiers of health care facilities. Magnetic tape specifications will be provided by DHEW.

IV. Approval Process for Implementation of PSRO Data Program

The PSRO will be expected to comply with the following procedures for implementing its data program.

4.1 After reviewing options and engaging in preliminary discussions of services and costs with data service organizations, other PSROs and the hospitals concerned and, in some instances, conducting site visits, the PSRO(s) will include in the data plan to be submitted for review and approval:

4.1.1 An explanation of the approach to be taken to satisfy its program needs, the reasons for selection or rejection of alternate options available where applicable, and a statement to the effect that all hospitals concerned agree to the action.

4.1.2 A list of optional data elements desired and justification for each.

4.1.3 A description and justification for non-routine data services.

4.1.4 A written justification where the PSRO wishes to routinely collect and computer process data elements in addition to those included under the seventy-five cent maximum. The additional per discharge cost estimate must also be submitted with the justification (See 3.11).

4.2 The PSRO is required to:

4.2.1 Request and/or obtain a written letter proposal from the candidate discharge data processing organization for costs of data collection services and costs for providing tape(s) of the PHDDS to the PSRO or its services subcontractor.

4.2.2 Prepare a scope of work covering the processing of data deliverables and other routine and non-routine services.

4.2.3 Issue an RFP on a competitive basis with routine inclusion of Federal regulations governing subcontracts.

4.2.4 Evaluate the proposals upon closing of the solicitation and reach a decision.

4.2.5 Prepare subcontracts and submit to the BQA Project Officer:

4.2.5.1 A cover letter indicating selection with an accompanying list of the sources sought and sources bidding, and an evaluation summary.

4.2.5.2 A copy of the selected proposal(s).

4.2.5.3 Copies of the prepared subcontract(s).

4.2.6 The Department will review and approve or disapprove with comment by letter.

4.2.7 The PSRO will award the subcontract(s).

PSRO Hospital Discharge Data Set (PHDDS)

Introduction

The PSRO Hospital Discharge Data Set (PHDDS) is a two-part set of data elements.

1. Part A - the Uniform Hospital Discharge Data Set (UHDDS)

2. Part B - PSRO-specific data elements

The UHDDS is a multi-purpose health data set whereas the remaining data elements are related to the review process.

The PHDDS will be the basis of reports produced for use in profile analysis, norms development, monitoring and management of review activities at the local level.

A subset of the PHDDS will be reported by PSROs to the Bureau of Quality Assurance. The elements to be included in this subset are asterisked. Although useful to the PSRO, certain elements from the PHDDS will not be required for Federal reporting for two reasons: (1) to conform with PSRO confidentiality policies; and (2) no need for certain elements exists at the Federal level.

The PSRO Hospital Discharge Data Set (PHDDS)

The PSRO is required to collect the elements of the PHDDS for all Medicare, Medicaid, and Title V discharges, according to the definitions below. Asterisks indicate those data which are to be reported to BQA.

A. UHDDS

1. Person Identification

Each admission is to be reported by the patient's unique social security number. For newborns and children not having a social security number but covered by Medicaid, the recipient I.D. number is to be used. (A unique number is essential to assure record linkage for multiple admissions of the same individual).

If the hospital also assigns a medical record number which differs from the social security number of the recipient I.D. number, it is also to be furnished (to facilitate retrieval of individual case records).

*2. Date of Birth

Month, day and year of birth

*3. Sex

Male, female

*4. Race

White, black, other

*5. Residence

ZIP code

*6. Hospital Identification

The provider number assigned by the Medicare Program and used by Medicare and Medicaid in the hospital certification process. NOTE: The Medicare provider number is not to be reported to BQA. For reporting purposes, the PSRO should use a unique hospital identifier assigned by the PSRO according to procedures to be provided by BQA.

*7. Admission Date and Hour

Month, day, year and hour of admission

*8. Discharge Date

Month, day and year of discharge

9. Attending Physician

This is the physician primarily responsible for the care of the patient from the beginning of this hospital episode. In determining the physician primarily responsible, the following criteria apply:

a. If the patient has a private attending doctor who arranged for his admission to the institution and directed his care therein, this physician is normally considered to be the attending physician in the hospital.

b. If the patient does not have a private doctor, the physician primarily responsible in the hospital is the staff member or resident to whom the patient is assigned and for whose care he/she is legally responsible.

The physician is to be identified by his/her unique social security number.

10. Operating Physician

This is the physician who performed the principal procedure. The physician is to be identified by his/her unique social security number.

*11. Diagnoses (Principal and Other)

All diagnoses that affect the current stay.

a. Principal Diagnosis is to be designated and is defined as: The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

b. Other Diagnoses to be listed are:
All conditions that coexist at the time of admission, or develop subsequently, which affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on this hospital stay are to be excluded.
NOTE: BQA is working with other HEW agencies to finalize a Departmental UHDA and instructions for recording the elements of the UHDDS. When the format and instructions for its use are finalized, it is expected that specific procedures for diagnostic and procedural coding (including the number of codes, terminology to be used, who is to code the data) will be included and the reporting of this item will be changed accordingly. In the interim, PSROs are required to report the ICDA-8 or HICDA-2 code for the principal diagnosis. For each discharge on which diagnoses in addition to the principal are coded in the systems specified above and entered in computers for local use, report up to four additional diagnoses. For discharges on which diagnoses in addition to the principal are either not coded in the specified coding systems or are not computer-entered for local use, report only whether additional diagnoses existed.

*12. Procedures (Principal and Others)

a. All procedures performed in operating rooms are to be recorded with the dates. In addition to these procedures, all other significant procedures are to be recorded. A significant procedure is one which carries an operative or anesthetic risk or requires highly trained personnel or special facilities or equipment. Some examples of such procedures are cardiocatheterization, angiography, endoscopy, and supervoltage radiation therapy.

b. When more than one procedure is recorded the principal procedure is to be designated. In determining which of several procedures is the principal, the following criteria apply:

(1) The principal procedure is one which was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.

(2) The principal procedure is that procedure most related to the principal diagnosis.

NOTE: BQA is working with other HEW agencies to finalize a Departmental UHDA and instructions for recording the elements

of the UHDDS. When the format and instructions for its use are finalized, it is expected that specific procedures for diagnostic and procedural coding (including the number of codes, terminology to be used, who is to code the data) will be included and the reporting of this item will be changed accordingly. In the interim, PSROs are required to report the ICDA-8 or HICDA-2 code for the principal procedure and the date on which the principal procedure was performed. For each discharge on which procedures in addition to the principal are coded in the systems specified above and entered in a computer for local use, report up to three additional significant procedures and the dates each was performed. For discharges on which procedures in addition to the principal are either not coded in the specified systems or are not computer-entered for local use, report only whether additional significant procedures were performed.

*13. Disposition of Patient

a. Discharged or transferred to another short-term hospital

b. Discharged or transferred to skilled nursing facility (SNF)

c. Discharged or transferred to an intermediate care facility (ICF)

d. Discharged or transferred to another institution

e. Discharged to home or self-care (routine discharge)

f. Discharged to home under care of an organized home health service.

g. Left against medical advice

h. Died

*14. Expected Principal Source of Payment

a. Self-pay

b. Workmen's compensation

c. Medicare

d. Medicaid

e. Other Government Payment (e.g., CHAMPUS)
   (1) Title V
   (2) Other

f. Blue Cross

g. Insurance Company

h. No charge (free, charity, special research, or teaching)

i. Other (e.g., relatives, friends)

NOTE: The UHDDS does not separate Title V from other government programs as an expected payment source. Since Title V, like Medicare and Medicaid, is specifically included under PSRO review, we have made it a separate category under "other government payment." BQA is working with other HEW agencies to finalize a Departmental UHDA and instructions for recording the elements of the UHDDS. When the format and instructions for its use are finalized, the reporting of this item may change.

B. PSRO-Specific Data Elements

*15. Number of Days Assigned at Admission

Record the number of days (00-99) of hospital stay certified at admission. To determine this number, start counting from the date of the patient's admission to the hospital.

In some instances where the admitting diagnosis or condition is not clear, additional reviews are conducted to allow time for resolution of the patient's condition. In these instances:

- If, during additional review, a diagnosis is established and a length of stay is certified based on the diagnosis, record the number of days certified using the admission date as the initial day of the period.
- If no diagnosis is established during the additional reviews conducted at frequent short (e.g., two- or three-day) intervals throughout the patient's stay, record the number of days between admission and the first review date.

*16. Admission Certification Process

Indicate the admission review procedure used and the outcome:

- Pre-admission review: certification granted
- Concurrent admission review: certification granted
- Concurrent admission review: certification denied

*17. Basis for Assignment of Initial Length of Stay

Indicate if PSRO-approved standards and norms were used to predict the expected length-of-stay for this patient at admission certification. Usually, patients with unclear or multiple diagnoses will be assigned a review or certification date by some method other than such norms or standards, and would be reported in this item as not having these norms and standards applied.

*18. Admission Certification Level of Review

Indicate if the patient's admission was certified by the review coordinator (i.e., the first level of review). If the admission was referred to a physician advisor (or a physician committee fulfilling this function), this level of review should be indicated. Count as referrals all cases referred to the physician advisor for a decision about the patient's certification, including whether the certification should be granted or denied, what length-of-stay should be certified, etc. For cases where the admitting diagnosis or condition is not clear and multiple reviews are conducted to allow time for resolution of the patient's condition, use the first review for completing this item.

*19. Total Number of Days Certified

Record the total number of days of hospital stay (00-999) certified at all reviews, including admission certification and any subsequent reviews for the patient. This number includes all days of stay certified regardless of whether the days were actually used by the patient. This number will also include the number of days between admission and admission certification.

Not to be included are "grace period" days which are days of patient stay following certification expiration which are statutorily permitted so that the patient and/or physician can make satisfactory arrangements for discharge and are reimbursable.

*20. Total Number of Reviews Referred to Physician Advisor

Record the total number (0-9) of reviews referred to a physician advisor (or physician committee fulfilling this function) for a decision to certify admission and all subsequent extensions for this patient. This includes certifications both granted and denied by the physician advisor. Count as referrals all cases referred to the physician advisor for a decision about the patient's certification, including whether the certification or extension should be granted, what length-of-stay should be certidied, etc. If more than one physician (or committee) reviewed an admission or extension request, it should be counted as one review for this item. For cases where the admitting diagnosis or condition is not clear and multiple reviews are conducted to allow time for resolution of the patient's condition each review is to be included for completing this item.

*21. Total Number of Extensions Approved

Record the total number (0-9) of extensions of hospital stay beyond the stay certified at admission which were approved by the review coordinator and/or physician advisor for this patient. For cases

where the admitting diagnosis or condition is not clear and multiple reviews are conducted to allow time for resolution of the patient's condition, each review is to be included for completing this item.

*22. Extension Denial

Indicate if any extension of hospital stay beyond the stay certified at admission was denied by the physician advisor, physician committee or PSRO for this patient.

Admission certification denials are not included.

A request for an extension for a certain number of days which is partially granted (that is, an extension for a lesser number of days is approved) is not counted as an extension denial for this item.

APPENDIX 2

SPECIFICATIONS FOR
CONFIDENTIALITY POLICY
ON PSRO DATA AND INFORMATION

For the purposes of this paper, the following definitions shall apply:

A. PSRO Data and Information

Data and information which is acquired and/or generated by any PSRO.

B. Individual PSRO Data and Information

Computer or hard copy data and information identifiable to a specific individual.

C. Identifiable Data or Information

Data and information collected, generated or aggregated on a particular individual which identifies that individual either explicitly or by implication.

D. Privileged Data and Information

Medical data and information identifiable to an individual patient, data and information indicating patterns of health care practices identifiable to individual health care practitioners, records of PSRO determinations identifiable to individual health care practitioners and data and information collected and/or generated for MCE studies as defined in department regulations and guidelines.

E. Monitoring

The review and appraisal of PSRO functions.

F. Evaluation

The determination of program effectiveness and the impact of the PSRO program on quality of care and utilization of services.

G. PSRO Review System

A system comprised of the PSRO and all supporting components which assist the PSRO in the review process or are furnished PSRO data for administrative purposes under Titles 18, 19, and 5 of the Social Security Act. The system may include (but is not limited to):

1. Hospital(s) if delegated review authority
2. PSRO review coordinator(s) - individuals responsible for carrying out PSRO activity within the health care facility
3. Medicare Intermediary(s)
4. Independent Health Data System(s), e.g., discharge abstract service
5. The PSRO
6. Medicaid State Agencies and Fiscal Agents

7. PSRO Contractors (any independent vendors providing data or data processing services to the PSRO)

8. Medicare Carriers

9. Other PSROs

10. DHEW

11. PSRO Support Centers

12. State PSRO Council

13. State Maternal and Child Health Agencies (Title V)

H. Health Care Practitioners

Physicians and other health care practitioners who are reimbursed for services through Medicare, Medicaid, or Maternal and Child Health programs.

I. Health Care Facilities

Organizations and institutions involved in the delivery of health care services (e.g., hospitals, nursing homes, outpatient facilities, etc.)

J. Sanction Proceedings

Procedures under Section 1157 and 1160 of the Social Security Act commencing with the forwarding of a sanction report by the PSRO under Section 1157.

K. PSRO Deliberations

Minutes of meetings, notes, comments, or other forms of recording which evidence internal PSRO discussions pertaining to review or sanctions.

1. Notification to Public

The PSRO must establish and implement a procedure for public notification of the existence, scope and purposes of PSRO data system.

2. Notification to Patients, Practitioners, and Providers

The PSRO must establish and implement procedures to inform individual patients, health care practitioners and health care facilities on whom PSRO data and information has been or is being collected as to:

a. the name, title and address of the person immediately responsible for the PSRO data system

b. those who will have access to the file

c. the circumstances under which and the purposes for which PSRO data and information will be disclosed

The procedures for notification should be administratively efficient, but provide at a minimum for general notification of the above.

3. Obtaining Access to own PSRO Data and Information

Subject to restrictions on disclosure of PSRO deliberations (see #19), patients, health care practitioners and health care facilities must be allowed access, upon request, to their individual PSRO data and information for purposes of ascertaining the accuracy of that data and information. The PSRO must establish and implement procedures to verify the accuracy of the data and information; the data and information to be accessed shall not be physically removed and/or transmitted outside of the PSRO.

4. Patient Access: Special Procedures

When a patient requests access to PSRO data and information under paragraph 3 above, the physicians of record must be notified in writing at least ten working days prior to patient access. The patient will not require physician authorization to access his individual PSRO data and information nor can the physician prevent patient access to the data and information. However, if upon receiving notification of intended patient access, a physician of record objects to the release of such information without classification, he or his designee may be present when the patient accesses his individual file to make such clarification.

5. Limitation on Data Collection

The PSRO or any agent, organization or institution acting on its behalf as a collector, processor and/or reviewer of information must limit the collection of PSRO data and information to that necessary for the purposes of PSRO review and/or evaluation.

6. Limitation on Data Access

Each component of the PSRO review system will have access only to that PSRO inforamtion and data necessary to carry out its functions within the system.

7. Limitations on Establishment of a National PSRO Data Base

Privileged data and information shall not be stored in a manner which constitutes creation of a national PSRO data base.

8. Codification of Personal Identifiers

Identification of individual patients, health care practitioners and health care facilities on PSRO generated reports and forms must be in a coded form except for verification purposes as provided for in paragraph 3 above. Index files containing cross reference of codes to names of patients, practitioners and facilities will be maintained in a secure manner within the PSRO review system.

9. Purgation: Computer Files

Computer files may be maintained indefinitely; however, each PSRO must purge such files of all personal identifiers as soon as such identifiers are no longer necessary (guidelines recommending time periods will be developed) for purposes of review, appeals, program monitoring and program evaluation.

10. Purgation of Hard Copy

Privileged information maintained in hard copy must be purged when that information has served the specific purpose for which it was generated.

11. Responsibility for Confidentiality Vested in a Single Individual

A single individual within the PSRO must be assigned the responsibility for maintaining the confidentiality of PSRO data within the PSRO review system and for the notification to DHEW of any breaches of confidentiality within the review system. A plan for implementing this responsibility will be submitted to DHEW for approval.

12. Responsibility of Officers and Employees

All officers and employees of the PSRO and components of the PSRO review system must be made aware of their responsibility to maintain the confidentiality of PSRO data and information and of the legal penalties which may be assessed for unauthorized disclosure of PSRO data or information (i.e., fined not more than $1,000 and/or imprisoned not more than six months, under section 1166(b) of the Social Security Act).

13. Authorized Access: Requirements

An individual officer or employee of a component of the PSRO review system may not be authorized access to privileged PSRO data and information until that individual:

a. Has completed a training program in the handling of such data and information pursuant to paragraph 14 below; and

b. Has signed a statement indicating that: (1) the individual recognizes his responsibility to hold the data in confidence, and (2) is aware of the legal penalties which may be assessed for unauthorized disclosure of such data and information (i.e., fined not more than $1,000 and/or imprisoned not more than six months).

14. Training Requirements

It is the rsponsibility of the PSRO to provide an ongoing program of training in the handling of PSRO privileged information for those officers and employees of PSRO review system components authorized to handle such data.

15. Access to Hard Copy

Each access to privileged data and information which requires removal of the data or information outside of a PSRO review system component, must be recorded in such a manner as to indicate what material was accessed, purpose, when, by whom, where the material was taken, and when returned. A separate log shall be kept recording access to the index code file (see paragraph 8). This log shall indicate the purpose of access, when, and by whom.

16. Disclosure: Licensing Boards

Copies of sanction reports forwarded to the Secretary of DHEW under Section 1157 of the Social Security Act may at the same time be forwarded to state licensing boards. However, the practitioner or facility must be notified in writing at least 15 working days prior to disclosure to permit the submission of a statement to accompany the disclosure sanction report. If the licensing board has been forwarded a copy of a sanction report, the PSRO shall inform the licensing board of the DHEW determination within a reasonable time after determination is made.

17. Disclosure: Civil litigation

Subject to regulations governing administrative hearings under section 205(b) of the Social Security Act, privileged data and information, PSRO sanction reports and PSRO deliberations shall not be subject to subpoena or discovery proceedings in any civil action; nor shall any PSRO member, employee or consultant be subject to subpoena or discovery proceedings for the purpose of obtaining information relating to the above.

18. Disclosure: Claims Appeals

In claims appeals disclosure of privileged data or information to other than the claimant or his representative must be limited to those parties involved in the appeals process.

19. Disclosure: PSRO Deliberations

PSRO deliberations concerning patients, practitioners and facilities which serve as a basis of PSRO decisions shall not be disclosed outside the PSRO.

20. Disclosure: Sanction Proceedings

Subject to regulations governing administrative hearings under section 205(b) of the Social Security Act, and provisions for judicial review, privileged data and information and sanction reports may be disclosed for purposes of sanction proceedings, but disclosure is limited to physicians or facilities subject to sanction or their representatives, the appropriate Statewide Council for purposes of review and comment, and the Secretary or his authorized representatives for purposes of sanction determinations.

21. Disclosure: Results of Sanction Proceedings

If sanctions are levied on health care practitioners or health care providers by the Secretary pursuant to Section 1160(b)(2), the name of the sanctioned party, the action taken and the nature of the sanction must be made a matter of public record by both the Secretary and the PSRO.

22. Disclosure: Monitoring, Review and Evaluation

For purposes of Federal and State program monitoring, review, and evaluation, privileged data and information may only be accessed by on-site visits to the PSRO or the other components of the PSRO review system in which the privileged data and/or information is stored. Privileged information or data may not be physically removed and/or transmitted outside of the PSRO review system except for the purpose of appeals or sanctions. Pursuant to paragraph #8 all privileged information and data needed for monitoring and program review purposes must cortain all personal identification in a coded form.

23. Disclosure: Health Care Facility Information

Non-privileged data and information acquired and/or generated by any PSRO, its agents or ancillary components supporting PSRO review which is uniquely identifiable to a given health care facility may be disclosed upon request and payment of a fee to cover the expense of copying the requested information. However, the health care facility must be notified in writing 30 days prior to disclosure to permit the facility to review the information for accuracy and to provide comments to accompany the disclosed information.

24. Disclosure: Non-Privileged Information

Non-privileged information and reports generated within the PSRO may be disclosed to individuals, organizations and institutions upon request and payment of a fee to cover the expense of copying the requested information.

25. Specific Requests for the Generation of Non-Privileged Information

Specific requests for the generation of non-privileged information for research, evaluation and health planning purposes to be conducted by parties independent of the PSRO program will be processed on request and payment of a fee to cover the expense of producing the requested information subject to efficient program administration.

26. Freedom of Information Act

Reports generated by the PSRO containing information required by Federal agencies in their monitoring and program review capacity are considered to come under the Freedom of Information Act and once received by DHEW are subject to its disclosure provisions.

27. Disclosure: Other

Disclosure or access other than that described in this policy must be referred to the Secretary of DHEW.

Discussion of Options

The PSRO during its planning stage will have become reasonably familiar with those data processes and services now being performed in and for acute care hospitals: the claims payment processes of Medicare, Medicaid and private insurers; State and local health statistics systems collecting hospital care information or preparing to do so; and the independent discharge abstract service organizations to which a large number of hospitals subscribe for a variety of hospital and medical information.

For purposes of discussion it should be noted that for years efforts have been underway to come up with a uniform method for obtaining basic hospital discharge data to service multiple needs for such information. It is expected that the Uniform Hospital Discharge Data Set will be collected uniformly at least for Medicare discharges beginning in 1976. It may be anticipated that Medicaid, rather than revise existing claims forms and systems, may elect to collect discharge data using a uniform abstract.

The Options for the Provisional Period

The major factors to be considered by both the PSRO and the existing information service organizations is the use of uniform abstract(s) and the elimination of duplicative recording and data reduction to the fullest extent possible. The PSRO, in considering options for the short range, should be guided by the assumptions that whatever existing discharge data collection system they seek to use will either continue with its current abstract services (with additional data fields to accomodate PSROs) or be expected in time to change to a uniform abstract format. In those instances, where major revisions to existing data collection forms or new systems forms are contemplated, a uniform abstract should be used as the basic format, as called for in the requirements.

In the following discussion of routing and processing options open to the newly designated conditional PSRO, both the policy guidelines and requirements and constraints previously stated are assumed and are not repeated. PSROs are expected to examine all possible options in arriving at the most economical and efficient handling of data consistent with the policies outlined in Section II and the requirements and constraints of Section III. Data service organizations already collecting part of the PSRO data requirements should agree to expand to collect all PSRO data requirements. The order in which these options are presented is based upon such priority considerations as: duplication in recording of data program coverage, ease of routing, timeliness of implementation, impact and probable costs. Alternatives, other than listed below, will be considered on a case by case basis.

Option I

Single Statewide Health Statistics System is Collecting Discharge Data Or Is Prepared To Do So In the Immediate Future.

If these systems collect and process information on all Federal patients within the hospitals, this is an excellent option. It provides for non-duplication in

the recording and collection of data (if used for multiple purposes), a single statewide data base, and a single formatted set of PSRO reports. It also offers the following potential cost advantages:

(a) reduced costs of collecting and producing tapes of PHDDS elements

(b) a group rate for processing deliverables for PSROs in the State including an opportunity to negotiate for additional routine and non-routine processing services.

Routing is simple and direct. The discharge abstracts are provided to a central processor for keying to machine tape.

Processing

The processing facility can perform the services and can furnish tapes of the PHDDS data elements for use in a single format.

Comments:

(a) Depending on arrangements that could be made this option would be a candidate for a sole source waiver by the Department covering design and competition.

(b) For those statewide organizations in the early development stage of a module for patient discharges, the PSRO should press for uniform data elements collected in uniform formats as described in Section 3.1.

Option II

Single Hospital Abstract Service Organization is Serving all Hospitals in the State.

The above applies equally to this option except that the central processor may be out of State. Option I, (comment (b)) is not applicable unless the abstract service is contemplating the complete revision of its forms and computer programs.

Option III

Medicare, Medicaid and Title V Begin Collection of UHDDS Using a Uniform Discharge Data Abstract to Supplement Claim Forms.

Medicare intermediaries are expected to have access to all data in the UHDDS by January 1, 1976. If concurrent action is taken by Medicaid and Title V State Agencies to supplement the claims form with abstracted data similar to Medicare and thus provide for full Federal patient coverage, this provides the PSRO with a principal option.

Option IV

Single Statewide Data System is Supporting an Existing Concurrent Review System, Such as CHAMP or HASP.

If the system has proven satisfactory for an existing concurrent review

system the PSRO may wish to expand the data system to include all Federal patients. This option may provide for a direct transition from the prior review system to PSRO review.

Option V

A Local Health Statistics System is Collecting Discharge Data in One or More PSRO Areas or is Prepared To Do So in Immediate Future.

If the system is collecting data on all Federal patients, this option provides similar advantages to Option I but on a reduced scale. The computer would be located within the immediate area. Routing and processing are simple and direct. The same comments as in Option I apply.

Option VI

Single Abstract Service Organization is Subscribed to by all Hospitals in the PSRO Area.

Same advantages as Option I but on a reduced scale. The data processing will normally be located outside the PSRO area. The abstract service organization, whether national or regional, may provide a special PSRO group rate based on services provided nationally and regionally.

Comment:

The PSRO may elect to negotiate for data collection only and go out on competitive bids for processing services.

Option VII

All Hospitals in the PSRO Area Subscribe to an Abstract Service Organization But More Than One Abstract Service Operates in the PSRO Area.

If the abstract services agree to pool or complement one another in collecting and producing a single PSRO areawide data base of PHDDS elements this becomes an option.

Routing:

This will require modifications of one or more forms, and/or the delivery from one of the abstract services to the other or to another EDP organization of a tape copy of the data elements requiring both reformating and merging operations to produce a single data base tape.

Processing:

Processing can be done either by the abstract service or independent data processor.

Comment:

A competitive situation for processing services.

Option VIII

All Hospitals in the PSRO Area Do Not Subscribe to Abstract Service Organizations

If the abstract service has all but a few hospitals subscribing to its services, and these few hospitals, while not willing to subscribe for services, are willing to supply the minimum PHDDS on a form approved by the PSRO this approach as an interim data collection approach should be given serious consideration.

Routing will be to the abstract service processor who will furnish tapes or provide processing services.

Processing Services

A competitive situation for processing services.

Option IX

There Is A Mix where some hospitals are subscribing to one or more abstract service organizations; or other Government subsidized systems are collecting discharge data from some but not all hospitals, or for some but not all patients; or there is no dishcarge data being collected from several hospitals other than through the claims processes.

The PSRO and the hospitals concerned will need to work out the most satisfactory compromise for data collection following the rule of favoring that system which has the greatest institutional coverage and is collecting data on all Federal patients. In such instances, the PSRO and hospitals may direct one or more data collection systems to supply computer tapes covering their hospitals -- formated to the needs of the subcontractor providing PSRO processing services -- and institute a uniform data abstract form and procedures in hospitals not covered by the system(s). Where necessary, the PSRO and hospitals may introduce a uniform abstract format and require all existing systems to revise their collection forms to conform with the standard format. In such instances, all concerned must work out a satisfactory multiple copy form. In this latter case one copy of the multiple form would be furnished directly to the PSRO subcontractor for processing.